CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

# Adult Health History and Review of Systems

Today's Date: _____ Patient Name: _____ Date of Birth: _____

| MEDICAL PROBLEMS SINCE YOUR LAST VISIT<br>Please list any major problems or consults you have had since your last visit here, please include the name of the provider you saw. |
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| MEDICATIONS<br>Please list <u>all</u> medications that you take, prescription and non-prescription | |
|---|---|
| **Medication** | **Dose** |
| | |
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| MEDICATION ALLERGIES<br>List any reactions you have had to medications (for example, penicillin or sulfa) <u>Please list new allergies first.</u> |
|---|
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| |

| FAMILY HISTORY<br>Please circle the problem and give the age when the problem began, if known. | | | | | |
|---|---|---|---|---|---|
| **ILLNESS** | **MOTHER** | **FATHER** | **SISTERS** | **BROTHERS** | **GRANDPARENTS** |
| Diabetes | | | | | |
| Breast, prostate or colon cancer | | | | | |
| Heart disease or heart attack | | | | | |
| High blood pressure | | | | | |
| **Stroke** | | | | | |
| **Alcoholism** | | | | | |
| **Osteoporosis (weak bones, hip fracture)** | | | | | |
| **Depression / Anxiety / Bipolar** | | | | | |
| **Gall Bladder / Kidney Stones / Stomach Ulcer** | | | | | |
| **Other** | | | | | |

| CURRENT HEALTH PRACTICES |
|---|
| Do you exercise regularly? **YES** **NO** If yes, what type of exercise: _____<br>Do you feel it is important to lose weight at this time? **YES** **NO** |
| Do you drink alcohol? **YES** **NO** If yes, what kinds: _____ |

On average, how much do you drink per day: _____ Per week: _____

Have you ever used tobacco products regularly? **YES** **NO** If yes, please answer the following:
Tobacco Product: _____ Age Started: _____ Years Used: _____ Average amount per day: _____
Are you still using: **YES** **NO** Year Quit: _____

Do you drink caffeine products? **YES** **NO** If yes, how much per day: _____

Do you use marijuana? **YES** **NO** If yes, how much and how often: _____

How often do you use your seatbelt: **ALWAYS** **SOMETIMES** **NEVER**

## Check any of the following symptoms you have experienced WITHIN THE PAST 3 MONTHS

**General:**
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Concerned about weight
- ☐ Abnormal weight gain
- ☐ Abnormal weight loss
- ☐ Fatigue
- ☐ Weakness
- ☐ General feeling of discomfort
- ☐ Sleep disorder
- ☐ Persistent infections
- ☐ HIV exposure

**Respiratory:**
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing
- ☐ Breathing disturbs sleep
- ☐ Coughing up blood
- ☐ Excessive sputum
- ☐ Snoring
- ☐ Excessive snoring
- ☐ Asthma

**Cardiovascular:**
- ☐ Chest pain or discomfort
- ☐ Fainting
- ☐ Near fainting
- ☐ Pain in legs with exertion
- ☐ Palpitations
- ☐ Shortness of breath at night
- ☐ Shortness of breath when lying down
- ☐ Shortness of breath with exertion
- ☐ Swelling of hands or feet
- ☐ Vertigo (Dizziness)
- ☐ Weight gain
- ☐ Bluish color lips/nails

**Eyes:**
- ☐ Decreased vision
- ☐ Double vision
- ☐ Eye pain
- ☐ Vision loss – 1 eye
- ☐ Eye irritation
- ☐ Blurring
- ☐ Vision loss – both eyes
- ☐ Halos
- ☐ Light sensitivity
- ☐ Eye discharge
- ☐ Eye injury
- ☐ Eye debris
- ☐ Ocular migraine

**GI:**
- ☐ Abdominal pain
- ☐ Blood in stools
- ☐ Dark tarry stools
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Frequent indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Heartburn
- ☐ Difficulty swallowing
- ☐ Excessive appetite
- ☐ Loss of appetite
- ☐ Hernia

**Muscle Skeletal:**
- ☐ Back pain
- ☐ Neck pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint fluid present
- ☐ Muscle pain
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Loss of muscle
- ☐ Gout
- ☐ Arthritis
- ☐ Stiffness
- ☐ Knee pain
- ☐ Shoulder pain

**Ears, Nose, Throat:**
- ☐ Decreased hearing
- ☐ Difficulty swallowing
- ☐ Dizziness
- ☐ Hoarseness
- ☐ Sinus congestion
- ☐ Sore throat
- ☐ Nasal congestion

**Urinary (GU):**
- ☐ Discharge
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Frequent night time urination
- ☐ Frequent
- ☐ Problems/changes with stream

**Dermatology:**
- ☐ Rash
- ☐ Change in moles
- ☐ Suspicious lesions
- ☐ Excessive sweating
- ☐ Night sweats
- ☐ Changes in nail beds
- ☐ Dry skin

- ☐ Ear ache
- ☐ Ringing in ears
- ☐ Ear discharge
- ☐ Nose bleeds
- ☐ Enlarged tonsils
- ☐ Enlarged adenoids
- ☐ Foul urinary discharge
- ☐ Inability to empty bladder
- ☐ Urinary urgency
- ☐ Unusual urine color
- ☐ Kidney pain
- ☐ Genital sores
- ☐ Lack of sexual drive
- ☐ Abnormal vaginal discharge
- ☐ Poor wound healing
- ☐ Unusual hair distribution
- ☐ Skin cancer
- ☐ Itching
- ☐ Changes in skin color
- ☐ Flushing
- ☐ Yellow skin color
- ☐ Eczema (itchy or irritated skin)

**Check any of the following symptoms you have experienced WITHIN THE PAST 3 MONTHS**

**Neurology:**

- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Numbness
- ☐ Weakness
- ☐ Seizures
- ☐ Tremors
- ☐ Difficulty with concentration
- ☐ Poor balance
- ☐ Coordination difficulties
- ☐ Inability to speak
- ☐ Falling down
- ☐ Tingling
- ☐ Brief paralysis
- ☐ Visual disturbance

**Endo:**

- ☐ Cold intolerance
- ☐ Excessive urination
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Heat intolerance
- ☐ Weight change

**Allergy:**

- ☐ Bee sting allergy
- ☐ Food allergies
- ☐ Hives or rash

**Psychology:**

- ☐ Anxiety
- ☐ Depression
- ☐ Thoughts of suicide
- ☐ Eating disorder
- ☐ Sense of great danger
- ☐ Mental problems
- ☐ Thoughts of violence
- ☐ Frightening visions/sounds

**Hematology:**

- ☐ Abnormal bruising
- ☐ Bleeding
- ☐ Enlarged lymph nodes
- ☐ Skin discoloration
- ☐ Fevers

**Breast:**

- ☐ Left breast lump
- ☐ Right breast lump
- ☐ Nipple discharge
- ☐ Bloody discharge from nipple
- ☐ Breast pain
- ☐ Abnormal mammogram
- ☐ Breast enlargement
- ☐ Abnormal ultrasound